

# ADULT PROTECTIVE SERVICES INTAKE REPORT

Commonwealth of Virginia Department of Social Services

CLIENT BACKGROUND								
				FIPS CODE/LOCALITY		DATE OF REPORT		TIME OF REPORT
WORKER WHO TOOK CALL		ASSIGNED WORKER		CITY/COUNTY OCCURRED		DATE REPORT WRITTEN		TIME REPORT WRITTEN
NAME OF CLIENT (First, Middle, Last)				CLIENT TELEPHONE NUMBER			CLIENT SOCIAL SECURITY NUMBER	
ADDRESS				DIRECTIONS TO HOME				
CITY, STATE, ZIP								
AGE	BIRTH DATE	RACE	GENDER	MARITAL STATUS			EDUCATION	
INCIDENT BACKGROUND								
LOCATION OF INCIDENT		LIVING ARRANGEMENTS OF CLIENT			TYPE OF ALLEGED ABUSE/NEGLECT/EXPLOITATION (CHOOSE ALL THAT APPLY)			
<input type="checkbox"/> ADULT DAY CARE	<input type="checkbox"/> NURSING FACILITY	<input type="checkbox"/> ADULT FOSTER CARE	<input type="checkbox"/> NURSING FACILITY	<input type="checkbox"/> SELF-NEGLECT				
<input type="checkbox"/> ADULT FOSTER CARE	<input type="checkbox"/> OTHER	<input type="checkbox"/> ASSISTED LIVING FACILITY	<input type="checkbox"/> OTHER	<input type="checkbox"/> NEGLECT		ALLEGED SOURCE:		
<input type="checkbox"/> ASSISTED LIVING FACILITY	<input type="checkbox"/> OTHER'S HOUSE/APT	<input type="checkbox"/> HOMELESS	<input type="checkbox"/> OTHER'S HOUSE/APT	<input type="checkbox"/> PHYSICAL ABUSE		<input type="checkbox"/> SELF		
<input type="checkbox"/> DAY TREATMENT CENTER	<input type="checkbox"/> OWN HOUSE/APT	<input type="checkbox"/> LOCAL/REGIONAL JAIL	<input type="checkbox"/> OWN HOUSE/APT	<input type="checkbox"/> MENTAL ABUSE				
<input type="checkbox"/> HOMELESS	<input type="checkbox"/> SENIOR CENTER	<input type="checkbox"/> MH/MR FACILITY	<input type="checkbox"/> SHELTER	<input type="checkbox"/> SEXUAL ABUSE		<input type="checkbox"/> OTHER		
<input type="checkbox"/> HOSPITAL	<input type="checkbox"/> SHELTER	<input type="checkbox"/> MH/MR GROUP HOME		<input type="checkbox"/> FINANCIAL EXPLOITATION				
<input type="checkbox"/> LOCAL/REGIONAL JAIL	<input type="checkbox"/> SHELTER WORKSHOP				<input type="checkbox"/> OTHER EXPLOITATION			
<input type="checkbox"/> MH/MR GROUP HOME	<input type="checkbox"/> MH/MR FACILITY	COMMENTS/NOTES:						
	<input type="checkbox"/> TRANSPORTATION PROVIDER							
REPORTER BACKGROUND								
				ANONYMOUS		REPORTER IS A MANDATED REPORTER		
NAME OF REPORTER				<input type="checkbox"/> YES		<input type="checkbox"/> YES		
				<input type="checkbox"/> NO		<input type="checkbox"/> NO		
ADDRESS				REPORTER'S RELATIONSHIP / TITLE (SPECIFY)				
CITY, STATE, ZIP				COMMENTS/NOTES:				
TELEPHONE NUMBER								
INTERESTED PERSONS OR AGENCIES								
NAME	ADDRESS			TELEPHONE NUMBER			RELATIONSHIP	

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ALLEGED PERPETRATORS			
NAME	ADDRESS	TELEPHONE NUMBER	RELATIONSHIP
PHYSICIANS (IF KNOWN)			
NAME	ADDRESS	TELEPHONE NUMBER	
MEDICAL INFORMATION			
DESCRIPTION OF MEDICAL PROBLEMS:		DESCRIBE INCAPACITY OF THE ALLEGED VICTIM	
CIRCUMSTANCES THAT DESCRIBE ABUSE/NEGLECT/EXPLOITATION OF THE ADULT			
REPORTER'S DESCRIPTION OF SITUATION			
INITIATION DECISION		DETERMINE REPORT VALIDITY (CHECK ALL THAT APPLY)	
IS THERE IMMINENT DANGER TO THE ADULT? <input type="checkbox"/> YES <input type="checkbox"/> NO		LIVING IDENTIFIABLE ADULT <input type="checkbox"/> YES <input type="checkbox"/> NO	
IS THE ALLEGED ABUSE, NEGLECT OR EXPLOITATION SEVERE? <input type="checkbox"/> YES <input type="checkbox"/> NO		60 YEARS OF AGE OR OLDER <input type="checkbox"/> YES <input type="checkbox"/> NO	
DO THE CIRCUMSTANCES SURROUNDING THE ALLEGATION REQUIRE IMMEDIATE RESPONSE? <input type="checkbox"/> YES <input type="checkbox"/> NO		INCAPACITATED ADULT <input type="checkbox"/> YES <input type="checkbox"/> NO	
IS THE PHYSICAL AND/OR MENTAL CONDITION OF THE ADULT AFFECTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		CIRCUMSTANCES DESCRIBE A/N/E <input type="checkbox"/> YES <input type="checkbox"/> NO	
		AGENCY OF JURISDICTION <input type="checkbox"/> YES <input type="checkbox"/> NO	
EMERGENCY <input type="checkbox"/> YES <input type="checkbox"/> NO		REPORT VALID <input type="checkbox"/> YES <input type="checkbox"/> NO	
APS CASE STATUS <input type="checkbox"/> OPEN <input type="checkbox"/> CLOSED <input type="checkbox"/> NEW			